

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025868

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7056

STATE FILE NUMBER

FILED JUL 12 1963

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. Louis

Length of stay in 1b
70 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

c. CITY OR TOWN St. Louis

Inside Limits
Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION St. Anthony Hospital

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
4057 McDonald Avenue

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First MARY Middle CHARLOTTE Last FOUBISTER

4. DATE OF DEATH
Month July Day 4, Year 1963

5. SEX
Female

6. COLOR OR RACE
White

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH
7/6/192

9. AGE (last birthday)
70 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Minister

10b. KIND OF BUSINESS OR INDUSTRY
Salvation Army

11. BIRTHPLACE (City and state or country)
St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY
USA

13a. FATHER'S NAME

Unknown Stahl

13b. MOTHER'S MAIDEN NAME

Eleanor Gerber

14. NAME OF HUSBAND OR WIFE

Mr. Frederick Foubister

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of)
No

16. SOCIAL SECURITY NO.

17. INFORMANT
Address
Mr. Gordon A. Foubister, 5329 Tholozan

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Heart Disease with
auricular fib and congestive heart
failure

INTERVAL BETWEEN
ONSET AND DEATH

unk

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)

20c. TIME OF INJURY
Hour s.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 5/28/63 to July 4 63 and last saw her alive on July 3-63
Death occurred, etc. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

23b. DATE
July 9, 1963

23c. NAME OF CEMETERY OR CREMATORY
Glen Oak Cemetery

23d. LOCATION (City, town, or county)
Chicago, Illinois

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Beiderwieden F.H.Inc., 1936 St. Louis (6)

JUL 8 1963

Earl Smith. M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

DATE AMENDED

VS 300
Rev. 4/59

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Dr. Robert M. Mendenhall, D.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by , Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Horner H. Fritz

Licensed Embalmer No. 3882

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.